

OF WISCONSIN
DWD
Department of Workforce Development

79 (N 03/2017)
s Compensation
Washington Ave
X 7901
n WI 53707

NSERVICE REQUESTED

COURIER DISTRIBUTION SYSTEMS LLC
% USMAN ESHAI
2200 NORCROSS PKWY STE 200
NORCROSS, GA 30071-3671

PRESORTED
FIRST CLASS



U.S. POSTAGE & PAYMENT
ZIP 53703 \$ 000.37
02 1M
0001301167 MAY 04 2017

CO
Update address

NRB-SSB 30087

CORR- 6650 SUGARLOAF PKWY STE 300 30090
[Barcode]



STATE OF WISCONSIN

Department of Workforce Development

WKC-18279 (N. 03/2017)

Worker's Compensation

201 E Washington Ave

P O Box 7901

Madison WI 53707

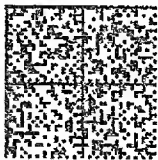
RETURN SERVICE REQUESTED

RECEIVED

JUL 06 2017

WORKERS COMPENSATION
DIVISION

PRESORTED
FIRST CLASS



U.S. POSTAGE & PAYMENT SERVICE
ZIP 53703 \$000.37
02 1W
0001391123 JUN 29 2017

NIXIE 530 DE 1300 0007/04/17

RETURN TO SENDER
INSUFFICIENT ADDRESS
UNABLE TO FORWARD

EC: 53707790101 *2986-02070-01-35

537077901

Madigan-Doucette, Denise M - DWD

From: Alex Jones <alex.jones@courierds.com>
Sent: Tuesday, August 01, 2017 2:57 PM
To: Madigan-Doucette, Denise M - DWD; Alex Jones
Subject: Fwd:
Attachments: 20170801155332142.pdf

Dear Ms. Madigan-Doucette,

Attached is the information that has been requested from the Department of Workforce Development.

Please feel free to contact me if you have any questions.

Regards,

Alex Jones



Director of Risk Management
Direct: 770-242-0454 Ext. 231
Mobile: 470-839-5371
Fax: 404-920-4384
alex.jones@courierds.com

*8/2/17 new penalty amount
would be: \$141,982.30.*

*Do you want me to
email her?*

-i- ENISS

REVISED INVOICE 1 FOR INVESTIGATION 651363

BIP No.	Debtor's SSN	WCRB No.	FEIN	UI No.	Class	Worksheet Type
6488843					7231	Regular

Employer Name
COURIER DISTRIBUTION SYSTEMS LLC

SOURCE
UEF Claim

Corporate Name

DBA Name
% USMAN ESHAI
Street Address
6650 SUGARLOAF PKWY

City	State	Zip Code	Telephone #
DULUTH	WI	30097-4359	(855) 237-3274

Business Status	Number of Employees	Period of Lapse	Coverage	OOB/NoEmployees
LIMITED LIABILITY	757	From:02/24/2017 TO:06/14/2017	Y	

TOTAL LAPSED DAYS = 111

1. Has the employer previously been penalized under s. 102.82?
If yes, what were the lapse dates? From: To:

2. Did an injury which the employer is liable for under s. 102.03 occur during the lapsed time Period?
If yes, attach the claim documentation

3. Does the penalty assessment under s. 102.82(2) (ag) apply?

5. Payroll Based on: ACTUAL <= 365

Lapse	Lapse Start	Lapse End	Lapsed Days	X Daily Avg Payroll	= Uninsured Payroll
1	02/24/2017	06/14/2017	111	\$1,196.07	0

Lapse	Eff. Date	Class Code	Rate(R)	Uninsured Payroll(U)	Percentage	RxU = Premium Evaded
1	10/01/2016	7231	16.26	436,566.95	100	\$70,985.79

Double Premium Evaded: \$141,971.58

If under \$750, invoice \$750, If over \$750, invoice the amount of premium X 2.

6. Initial Penalty Due: \$141,971.58 Preparer: MADIGDE Date: 08/02/2017

COURIER DISTRIBUTION SYSTEMS LLC
% USMAN ESHAI
6650 SUGARLOAF PKWY
DULUTH, WI 30097-4359

July 6, 2017

BIP #: 648-88-43
WCRB #: [REDACTED]

Our records indicate you did not have a Worker's Compensation insurance policy in force from 02/24/2017 to 06/14/2017. To verify the gross wages earned by your employees during the lapsed time period, please complete the questions below, verifying the total number of employees working and the total gross payroll earned by the employees during the lapsed time period indicated above. Do not count as employees or include the wages of sole proprietors, partners or members of limited liability companies and do not include the wages of exempt corporate officers. Provide the job classification breakdown if applicable.

1. The total number of employees working during the lapsed time period indicated above was: 757

2. The total gross payroll earned by your employees during the lapsed time period from 02/24/2017 to 06/14/2017:

\$ \$436,566.95

2a. If you have more than one job classification code on your worker's compensation insurance policy, you may provide a breakdown of the gross payroll for the lapsed period indicated in question 2, assigning it to the appropriate classification code in which it was earned. (Attach a separate sheet if additional space is needed.)

Job Classification Code	Gross Payroll Earned During Lapse
Classification Code: _____	\$ _____
Classification Code: _____	\$ _____
Classification Code: _____	\$ _____
Classification Code: _____	\$ _____
Classification Code: _____	\$ _____
Classification Code: _____	\$ _____

3. If you did not have employees during the lapsed time period indicated above, what was the last date you did have employees? _____

4. If you no longer have any employees, what was the last date you did have employees? _____

Name (please print) <u>Alex Jones</u>	Title <u>Director of Risk Management</u>	
Signature <u>[Signature]</u>	Date Signed <u>7/31/2017</u>	Telephone Number <u>770-242-0454 X231</u>

Scott Walker
Governor

Raymond Allen
Secretary



WORKER'S COMPENSATION
P.O. Box 7901
Madison, WI 53707-7901
FAX: (608) 266-6827

State of Wisconsin
Department of Workforce Development

COURIER DISTRIBUTION SYSTEMS LLC
% USMAN ESHAI
6650 SUGARLOAF PKWY
DULUTH, WI 55813-4359

July 6, 2017

BIP #: 648-88-43
WCRB #: [REDACTED]

Dear Employer:

Our records indicate that you did not have a worker's compensation insurance policy in force from 02/24/2017 to 06/14/2017 and that you may have been required to be insured during this time period. If any of this information is not correct, please advise me immediately.

Please provide the information requested in the questions on the reverse side of this letter to verify the number of employees working for you and the wages earned during the lapsed time period.

If it is determined that you were required to be insured during the lapsed time period identified above, you will be assessed a mandatory penalty for violation of the Wisconsin worker's compensation law. This penalty is twice the amount of premium not paid during the uninsured time period or \$750, whichever is greater. Under certain circumstances, if an employer's lapse in worker's compensation insurance coverage is less than seven (7) days, the penalty is \$100 per day. (See sections 102.82(2)(a) and 102.82(2)(ag) of the Wisconsin Statutes.)

Failure to respond to this letter and to provide the requested employment and payroll information will be considered acknowledgment by you that you were required to be insured during the lapsed period and in violation of the Wisconsin Worker's Compensation Act. If you do not provide the employment and payroll information requested, we will use the best available employment and payroll information to assess a mandatory penalty for failure to have the required insurance coverage in force during the lapsed time period.

Please complete the questions on the reverse side of this letter and return it within 15 days of the date of this letter.

Sincerely,

A handwritten signature in cursive script that reads "Denise Madigan-Doucette".

Denise Madigan-Doucette, Investigator - Worker's Compensation Division
Enforcement/Investigation Unit
(608) 267-0516 Fax # (608) 266-6827 denise.madigandoucette@dwd.wisconsin.gov

ORIGINAL INVOICE FOR INVESTIGATION 651363

BIP No. Debtor's SSN WCRB No. FEIN UI No. Class Wksheet Type
 6488843 [REDACTED] [REDACTED] [REDACTED] 7231 Regular

Employer Name
 COURIER DISTRIBUTION SYSTEMS LLC

SOURCE
 UEF Claim

Corporate Name

DBA Name
 % USMAN ESHAI
 Street Address
 6650 SUGARLOAF PKWY

City State Zip Code Telephone #
 DULUTH WI 30097-4359 (855) 237-3274

Business Status Number of Employees Period of Lapse Coverage OOB/NoEmployees
 LIMITED LIABILITY 71 From:02/24/2017 TO:06/14/2017 Y

TOTAL LAPSED DAYS = 111

1. Has the employer previously been penalized under s. 102.82?
 If yes, what were the lapse dates? From: To:

2. Did an injury which the employer is liable for under s. 102.03 occur during the lapsed time Period?
 If yes, attach the claim documentation

3. Does the penalty assessment under s. 102.82(2) (ag) apply?

5. Payroll Based on: UI QUARTERLY WAGE

Pay Year	Quarter	Payroll Amount
2016	3	\$364,140.92 ✓
2016	4	\$326,181.71 ✓
2017	1	\$322,461.51 ✓
2017	2	\$389,831.25 ✓
		<u>\$1,402,615.39</u>

Daily Avg = Total Payroll Amt / Days in Year
 $\$3,842.78 = \$1,402,615.39 / 365$

Lapse	Lapse Start	Lapse End	Lapsed Days	X Daily Avg Payroll	= Uninsured Payroll
1	02/24/2017	06/14/2017	111	\$3,842.78	426,548.58

Lapse	Eff. Date	Class Code	Rate(R)	Uninsured Payroll(U)	Percentage	RxU = Premium Evaded
1	10/01/2016	7231	16.26	426,548.58	100	\$69,356.80

Double Premium Evaded: \$138,713.60

If under \$750, invoice \$750, If over \$750, invoice the amount of premium X 2.

6. Initial Penalty Due: \$138,713.60

Preparer: MADIGDE

Date: 07/31/2017

OK
 7/31/17

Scott Walker
Governor

Raymond Allen
Secretary



WORKER'S COMPENSATION
P.O. Box 7901
Madison, WI 53707-7901
FAX: (608) 266-6827

State of Wisconsin
Department of Workforce Development

COURIER DISTRIBUTION SYSTEMS LLC
% USMAN ESHAI
650 SUGARLOAF PARKWAY
MILWAUKEE, WI 53215

June 28, 2017

BIP #: 648-88-43
WCRB #: [REDACTED]

Dear Employer:

Our records indicate that you did not have a worker's compensation insurance policy in force from 02/24/2017 to 06/14/2017 and that you may have been required to be insured during this time period. If any of this information is not correct, please advise me immediately.

Please provide the information requested in the questions on the reverse side of this letter to verify the number of employees working for you and the wages earned during the lapsed time period.

If it is determined that you were required to be insured during the lapsed time period identified above, you will be assessed a mandatory penalty for violation of the Wisconsin worker's compensation law. This penalty is twice the amount of premium not paid during the uninsured time period or \$750, whichever is greater. Under certain circumstances, if an employer's lapse in worker's compensation insurance coverage is less than seven (7) days, the penalty is \$100 per day. (See sections 102.82(2)(a) and 102.82(2)(ag) of the Wisconsin Statutes.)

Failure to respond to this letter and to provide the requested employment and payroll information will be considered acknowledgment by you that you were required to be insured during the lapsed period and in violation of the Wisconsin Worker's Compensation Act. If you do not provide the employment and payroll information requested, we will use the best available employment and payroll information to assess a mandatory penalty for failure to have the required insurance coverage in force during the lapsed time period.

Please complete the questions on the reverse side of this letter and return it within 15 days of the date of this letter.

Sincerely,

A handwritten signature in cursive script that reads "Denise Madigan-Doucette".

Denise Madigan-Doucette, Investigator - Worker's Compensation Division
Enforcement/Investigation Unit
(608) 267-0516 Fax # (608) 266-6827 denise.madigandoucette@dwd.wisconsin.gov

COUPLER DISTRIBUTION SYSTEMS LLC
% SMANESHAI
20 SUGARLOAF PARKWAY
MILWAUKEE, WI 53215

June 28, 2017

BIP #: 648-88-43
WCRB # [REDACTED]

Our records indicate you did not have a Worker's Compensation insurance policy in force from **02/24/2017** to **06/14/2017**. To verify the gross wages earned by your employees during the lapsed time period, please complete the questions below, verifying the total number of employees working and the total gross payroll earned by the employees during the lapsed time period indicated above. Do not count as employees or include the wages of sole proprietors, partners or members of limited liability companies and do not include the wages of exempt corporate officers. Provide the job classification breakdown if applicable.

1. The total number of employees working during the lapsed time period indicated above was: _____.	
2. The total gross payroll earned by your employees during the lapsed time period from 02/24/2017 to 06/14/2017 : \$ _____.	
2a. If you have more than one job classification code on your worker's compensation insurance policy, you may provide a breakdown of the gross payroll for the lapsed period indicated in question 2, assigning it to the appropriate classification code in which it was earned. (Attach a separate sheet if additional space is needed.)	
Job Classification Code	Gross Payroll Earned During Lapse
Classification Code: _____	\$ _____
Classification Code: _____	\$ _____
Classification Code: _____	\$ _____
Classification Code: _____	\$ _____
Classification Code: _____	\$ _____
Classification Code: _____	\$ _____
3. If you did not have employees during the lapsed time period indicated above, what was the last date you did have employees? _____.	
4. If you no longer have any employees, what was the last date you did have employees? _____.	

Name (please print)	Title	
Signature	Date Signed	Telephone Number

Scott Walker
Governor

Raymond Allen
Secretary



WORKER'S COMPENSATION
P.O. Box 7901
Madison, WI 53707-7901
FAX: (608) 266-6827

State of Wisconsin
Department of Workforce Development

COURIER DISTRIBUTION SYSTEMS LLC
% USMAN ESHAI
3935 W MITCHELL ST STE 300
MILWAUKEE, WI 53215

May 31, 2017

BIP #: 648-88-43
WCRB #: [REDACTED]

Dear Employer:

We have previously requested information regarding the status of your Worker's Compensation insurance policy. We have no record of a response. Our records indicate you may be an employer subject to the Wisconsin Worker's Compensation Act and you do not currently have the required worker's compensation insurance to operate in Wisconsin. You appear to have employees and should have a worker's compensation insurance policy. If our records are correct, you must obtain a worker's compensation insurance policy immediately.

Most Wisconsin employers are required to carry worker's compensation insurance under the Wisconsin Worker's Compensation Act. An employer becomes subject to the Wisconsin Worker's Compensation Act and must carry a worker's compensation insurance policy when:

- 1) the employer usually employs three or more persons full-time or part-time. This employer needs insurance immediately; or
- 2) the employer has one or more full-time or part-time employees and has paid gross combined wages of \$500 or more in any calendar quarter for work done in Wisconsin. This employer must have insurance by the 10th day of the first month of the next calendar quarter; or
- 3) a farmer who employs six or more workers on the same day for any 20 days during a calendar year. The farmer must have insurance 10 days after the 20th day of employment. A calendar year is January through December. Some relatives of the farmer are not counted as employees. Please call (608) 266-1340 for a detailed explanation of these exceptions.

It is mandatory for a subject employer to carry Worker's Compensation insurance if the employer has any employee. Failure to obtain Worker's Compensation insurance will result in the initiation of closure proceedings by the Department of Workforce Development, which will require you to cease operations until you are in compliance with the Wisconsin Worker's Compensation Act. (See section 102.28(4) of the Wisconsin Statutes.)

The penalty for failure to carry Worker's Compensation insurance when required, is twice the amount of premium not paid during an uninsured time period or \$750, whichever is greater. An employer who has a lapse in Worker's Compensation Insurance coverage can be subject to a penalty of \$100 for each day they are uninsured up to 7 days.

Please complete the attached form and return it within 15 days of the date this form was mailed. If you have any questions, please call me.

Sincerely,

A handwritten signature in cursive script that reads "Denise Madigan-Doucette".

Denise Madigan-Doucette, Investigator - Worker's Compensation Division
Enforcement/Investigation Unit
(608) 267-0516 Fax # (608) 266-6827 denise.madigandoucette@dwd.wisconsin.gov

PLEASE COMPLETE THE QUESTIONS AND THE EMPLOYER QUARTERLY WAGE REPORT BELOW

1. What date did you apply for a worker's compensation policy? _____
2. What is the name of the insurance company currently providing your worker's compensation insurance coverage? _____
3. What date did your current policy go into effect? _____
4. What is the policy number of your current policy? _____
5. What is the name and phone number of your insurance agent or agency?

Insurance Agent or Agency Name _____

Insurance Agent or Agency Telephone Number _____

If possible, attach a copy of the Information or Declaration Page of your policy.

Employer Quarterly Wage Record Report

Please complete the information requested in the spaces provided. Indicate the total gross payroll earned by your employees in each calendar quarter and the total number of employees that worked in each month of each calendar quarter. Do not count as employees or include the wages of sole proprietors or partners and do not include the wages of exempt corporate officers. Include up-to-date 2016 information.

If you no longer have any employee(s), what was the last date any employee(s) worked for you?

Last date any employee worked: _____

<u>2016</u> Year				
	<table border="1"> <tr> <td>Jan</td> <td>Feb</td> <td>Mar</td> </tr> </table>	Jan	Feb	Mar
Jan	Feb	Mar		
First Quarter \$ _____	<table border="1"> <tr> <td></td> <td></td> <td></td> </tr> </table>			
Payroll	Employees			
	<table border="1"> <tr> <td>Apr</td> <td>May</td> <td>June</td> </tr> </table>	Apr	May	June
Apr	May	June		
Second Quarter \$ _____	<table border="1"> <tr> <td></td> <td></td> <td></td> </tr> </table>			
Payroll	Employees			
	<table border="1"> <tr> <td>July</td> <td>Aug</td> <td>Sept</td> </tr> </table>	July	Aug	Sept
July	Aug	Sept		
Third Quarter \$ _____	<table border="1"> <tr> <td></td> <td></td> <td></td> </tr> </table>			
Payroll	Employees			
	<table border="1"> <tr> <td>Oct</td> <td>Nov</td> <td>Dec</td> </tr> </table>	Oct	Nov	Dec
Oct	Nov	Dec		
Fourth Quarter \$ _____	<table border="1"> <tr> <td></td> <td></td> <td></td> </tr> </table>			
Payroll	Employees			

<u>2017</u> Year				
	<table border="1"> <tr> <td>Jan</td> <td>Feb</td> <td>Mar</td> </tr> </table>	Jan	Feb	Mar
Jan	Feb	Mar		
First Quarter \$ _____	<table border="1"> <tr> <td></td> <td></td> <td></td> </tr> </table>			
Payroll	Employees			
	<table border="1"> <tr> <td>Apr</td> <td>May</td> <td>June</td> </tr> </table>	Apr	May	June
Apr	May	June		
Second Quarter \$ _____	<table border="1"> <tr> <td></td> <td></td> <td></td> </tr> </table>			
Payroll	Employees			
	<table border="1"> <tr> <td>July</td> <td>Aug</td> <td>Sept</td> </tr> </table>	July	Aug	Sept
July	Aug	Sept		
Third Quarter \$ _____	<table border="1"> <tr> <td></td> <td></td> <td></td> </tr> </table>			
Payroll	Employees			
	<table border="1"> <tr> <td>Oct</td> <td>Nov</td> <td>Dec</td> </tr> </table>	Oct	Nov	Dec
Oct	Nov	Dec		
Fourth Quarter \$ _____	<table border="1"> <tr> <td></td> <td></td> <td></td> </tr> </table>			
Payroll	Employees			

Name (please print) _____

Title _____

Signature _____

Date Signed _____

Telephone Number _____

UEF UNINSURED CLAIM INTAKE / TELEPHONE REPORTING FORM

Date: 05/12/2017

Investigator Name Denise

Open Investigation Exist Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	BIP # Wcrb FEIN #
Set up New Investigation Yes <input type="checkbox"/> No <input type="checkbox"/>	
Transferred File To: UEF – Denise Madigan-Doucette	

Attach UI Print out and Spectrum Print

Claim and Injury Information

Claimant Name, Social Security Number and DOB <div style="background-color: black; height: 1.2em; width: 100%; margin-top: 5px;"></div>	Claimant Telephone Number <div style="background-color: black; height: 1.2em; width: 100%; margin-top: 5px;"></div>	
DOJ: 5/7/17	Type Injury <div style="background-color: black; height: 1.2em; width: 100%; margin-top: 5px;"></div>	Type of Work Performed DELIVERY CARRIER
Other Employees Working/How Many / Names Hundreds of employees 75 ee's	How were you paid? Weekly, Biweekly, Monthly By Check By Cash? In-Kind? PAID WEEKLY BY CHECK	
Represented By Attorney: Yes or NO If yes who: <div style="background-color: black; height: 1.2em; width: 100%; margin-top: 5px;"></div> NO	Attorney Address:	

Employer Information

Employer Name/or Business Name COURIER DISTRIBUTION SYSTEMS LLC 3935 W MITCHELL ST STE 300 MILAUKKEE, WI 53215	Employer Telephone Number 770-403-5939		
Employer Address	City	State	Zip Code

Additional Information:

Looked under 0509607 COURIER DISTRIBUTION SYSTEMS LLC. Policy cancelled
02/24/17

—

—

—

Department of Workforce Development
Division of Worker's Compensation
P.O. Box 7901
Madison, WI 53707-7901
Telephone: (608) 266-1340
Fax: (608) 267-0394
TTY: (866) 265-3142
Email: dwddwc@dwd.wisconsin.gov

STATE OF WISCONSIN



Department of Workforce Development

Scott Walker, Governor
Raymond Allen, Secretary

May 12, 2017

RE: COURIER DISTRIBUTION SYSTEMS LLC – BIP 6488843
Date of Injury: May 7, 2017

COPY

Dear [REDACTED]

On May 12, 2017 you contacted the Wisconsin Worker's Compensation Division regarding a work related injury you sustained on May 7, 2017 while employed by Courier Distribution Systems LLC. The Division's initial review of the worker's compensation insurance policy records cannot identify a worker's compensation insurance policy for this employer.

If this employer was subject to the Wisconsin Worker's Compensation Act and did not have a valid worker's compensation policy in effect on the date you were injured, you may be eligible to receive worker's compensation benefits from the Uninsured Employers Fund.

The Uninsured Employers Fund (UEF) is administered by the Wisconsin Worker's Compensation Division. The UEF pays worker's compensation benefits on valid worker's compensation claims filed by employees who are injured while working for illegally uninsured Wisconsin employers. When a compensable claim is filed, the UEF pays the injured employee worker's compensation benefits as if the uninsured employer had been insured.

To file a UEF claim, complete and return the original enclosed Uninsured Employers Fund Claim Form (**faxes or photocopies of the application are not accepted**). Attach a copy of a check stub, W-2 form, payroll check, tax return, wage statement or similar employment information as documentation of your employment with this employer. If you do not have any documentation of your employment, you must attach a notarized statement explaining how and when you were paid, how much you were paid and the reason you are unable to provide any documentation. In addition, complete and return the enclosed Substitute W-9 Taxpayer Identification Number (TIN) Verification form. Failure to complete and return the Substitute W-9 form will delay payment of the claim. Mail the completed forms to the Worker's Compensation Division, P.O. Box 7901, Madison, WI 53707-7901.

After the claim is filed you will be contacted by the UEF claims administrator, The ASU Group. The ASU Group will handle the entire claim process including any questions you may have regarding the claim. The Division will continue to investigate the status of Courier Distribution Systems LLC under the insurance requirements of the Worker's Compensation Act.

If you have any questions regarding the UEF or if you need help filling out any part of the claim form, please call me at (608)267-0516.

Sincerely,

Denise M. Madigan-Doucette, Investigator
Worker's Compensation Division/Uninsured Employer Fund
ph 608-267-0516 fax 266-6827
denise.madigandoucette@dwd.wisconsin.gov

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

[illegible]

Scott Walker
Governor

Raymond Allen
Secretary

STATE OF WISCONSIN



Department of Workforce Development

WORKER'S COMPENSATION

P.O. Box 7901
Madison, WI 53707-7901
FAX: (608) 266-6827

State of Wisconsin
Department of Workforce Development

COURIER DISTRIBUTION SYSTEMS LLC
% USMAN ESHAI
3935 W MITCHELL ST STE 300
MILWAUKEE WI 53215

COPY

May 12, 2017

BIP #: 648-88-43
WCRB #: [REDACTED]

Dear Employer:

[REDACTED] has indicated that she was employed by COURIER DISTRIBUTION SYSTEMS LLC / % USMAN ESHAI and was injured while working on May 7, 2017.

To clarify our records regarding this injury and your status under the Wisconsin Worker's Compensation Act, please complete and return the enclosed *Employer's Report*, provide the information requested on page 2 of this letter and respond in writing to the following questions.

1. Was [REDACTED] employed by you?
2. If yes, did you have a valid worker's compensation policy in force on the date the injury occurred? If you had a policy in force on the date in question, please attach a copy of the *Information or Declaration Page* of the policy to the *Employer's Report*.
3. If Louvenger Phillips was not employed by you, please clarify what Louvenger Phillips's working relationship and status was with COURIER DISTRIBUTION SYSTEMS LLC / % USMAN ESHAI. Include copies of any documentation you have regarding [REDACTED] working relationship and status with you.

The penalty for failure to carry worker's compensation insurance when required, is twice the amount of premium not paid during an uninsured time period or \$750, whichever is greater. Under certain circumstances, an employer who has a lapse in Worker's Compensation insurance coverage can be subject to a penalty of \$100 for each day they are uninsured up to 7 days. In addition, an uninsured employer is personally liable for reimbursement to the Uninsured Employers Fund for benefit payments made by the Fund under section 102.81(1) of the Wisconsin Statutes, to an injured employee of the uninsured employer or to the employee's dependents. (see sections 102.82(2)(a), 102.82(2)(ag) and 102.81(1), of the Wisconsin Statutes.)

Failure to respond to this letter and to provide the requested employment and payroll information will be considered acknowledgment by you that: 1) a compensable worker's compensation injury did occur, 2) you were required to be insured at the time of the injury and 3) you were in violation of the insurance requirements of the Wisconsin Worker's Compensation Act. If you do not provide the employment and payroll information requested, we will use the best available employment and payroll information to assess a mandatory penalty for failure to have the required insurance coverage in force.

Finally, if you are operating without a worker's compensation insurance policy in violation of the law, your firm must take immediate action to obtain a worker's compensation policy issued by a Wisconsin licensed insurance carrier. Attach written documentation that your business has obtained a worker's compensation policy to the *Employer's Report*. Failure to obtain proper worker's compensation insurance could result in a "closure order" being issued under section 102.28(4) of the Wisconsin Statutes. This order would require your firm to cease operations until you comply with the insurance requirements of the Wisconsin Worker's Compensation Act. We hope that the Worker's Compensation Division will not have to take such actions. Please respond by June 6, 2017.

Sincerely,

Denise Madigan-Doucette, Investigator - Worker's Compensation Division
Enforcement/Investigation Unit
(608) 267-0516 Fax # (608) 266-6827 . denise.madigandoucette@dwd.wisconsin.gov

PLEASE COMPLETE THE QUESTIONS AND THE EMPLOYER QUARTERLY WAGE REPORT BELOW

1. What was the first date any employee worked for you? _____
2. What was the first date 3 or more employees worked for you? _____
3. How many employees currently work for you? _____
4. If you no longer have any employee(s), what was the last date any employee(s) worked for you?
Last date any employee worked: _____

Employer Quarterly Wage Record Report

Please complete the information requested in the spaces provided. Indicate the total gross payroll earned by your employees in each calendar quarter and the total number of employees that worked in each month of each calendar quarter. Do not count as employees or include the wages of sole proprietors or partners and do not include the wages of exempt corporate officers. ***Include up-to-date 2016 information.***

<u>2016</u> Year				
	<table border="1"><tr><td>Jan</td><td>Feb</td><td>Mar</td></tr></table>	Jan	Feb	Mar
Jan	Feb	Mar		
First Quarter \$ _____	<table border="1"><tr><td></td><td></td><td></td></tr></table> Payroll Employees			
Second Quarter \$ _____	<table border="1"><tr><td>Apr</td><td>May</td><td>June</td></tr></table> Payroll Employees	Apr	May	June
Apr	May	June		
Third Quarter \$ _____	<table border="1"><tr><td>July</td><td>Aug</td><td>Sept</td></tr></table> Payroll Employees	July	Aug	Sept
July	Aug	Sept		
Fourth Quarter \$ _____	<table border="1"><tr><td>Oct</td><td>Nov</td><td>Dec</td></tr></table> Payroll Employees	Oct	Nov	Dec
Oct	Nov	Dec		

Name (please print)

Signature

<u>2017</u> Year				
	<table border="1"><tr><td>Jan</td><td>Feb</td><td>Mar</td></tr></table>	Jan	Feb	Mar
Jan	Feb	Mar		
First Quarter \$ _____	<table border="1"><tr><td></td><td></td><td></td></tr></table> Payroll Employees			
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Apr	May	June		
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July	Aug	Sept		
Fourth Quarter \$ _____	<table border="1"><tr><td>Oct</td><td>Nov</td><td>Dec</td></tr></table> Payroll Employees	Oct	Nov	Dec
Oct	Nov	Dec		

Title

Date Signed

Telephone Number

THE WISCONSIN WORKER'S COMPENSATION UNINSURED EMPLOYERS FUND

What is the Uninsured Employers Fund?

The Uninsured Employers Fund (UEF) pays worker's compensation benefits on valid worker's compensation claims filed by employees who are injured while working for illegally uninsured Wisconsin employers. When a compensable claim is filed, the UEF pays the injured employee worker's compensation benefits as if the uninsured employer had been insured. The uninsured employer is responsible to reimburse the UEF for all costs of a claim paid by the fund.

How is the UEF funded?

It is funded through penalties assessed against employers for illegally operating a business without worker's compensation insurance. The penalties are mandatory and non-negotiable. In addition, the department pursues reimbursement from each uninsured employer of benefit payments made by the UEF under s. 102.81(1), Wis. Stats., to the employee of that uninsured employer or to the employee's dependents. The UEF uses aggressive collection action (including warrants, levies, garnishment and execution against property) to secure satisfaction of penalty assessments and reimbursement of claims paid by the fund.

When was the UEF implemented?

The UEF applies only to injuries occurring on or after July 1, 1996. Uninsured Employers Fund claims filed for injuries occurring prior to July 1, 1996 are not valid and will be denied.

How is a UEF claim form filed?

To file a claim, an injured worker must complete an Uninsured Employers Fund Claim Form and provide the required documentation. In addition, a claimant is expected to provide assistance to the department or its agent, including copies of relevant payroll checks, check stubs, bank records, wage statements, tax returns or other similar documentation in determining whether their employer is liable for the injury. A claimant is also required to document any medical treatment, vocational rehabilitation services and other bills or expenses related to a claim.

Will the department verify the information provided in a UEF claim form?

Yes, the claim will be thoroughly investigated. In verifying information submitted in support of a claim for compensation, the department or its agent may share information related to a claim with other government agencies, including those responsible for tax collection, unemployment insurance, medical assistance, vocational rehabilitation, family support or general relief.

What if an alleged uninsured employer refuses to cooperate with the department?

An employer who is alleged to be uninsured is required to cooperate with the department or its agent in the investigation of a claim by providing any records related to payroll, personnel, taxes, ownership of the business or its assets or other documents the department or its agent requests from the employer to determine the employer's liability under s. 102.03 of the Wisconsin Statutes. If an employer fails to provide requested information, the department may presume the employer is an uninsured employer and assess the appropriate penalties.

Once a UEF claim form is filed, how long does it take to process the claim?

Within 14 days after receiving a completed UEF claim form, the department or its agent will mail the first indemnity payment to the injured employee, deny the claim or explain to the employee who filed the claim the reason that the claim is still under review. The department or its agent will report to the employee regarding the status of the claim at least once every 30 days from the date of the first notification that the claim is under review until the first indemnity payment is made or the claim is denied.

Who can I contact for more information regarding the UEF?

Call or write the Wisconsin Worker's Compensation Division, Bureau of Insurance Programs. Our mailing address is P.O. Box 7901, Madison, Wisconsin 53707-7901. Our telephone number is (608) 266-1340 or you can reach us by fax at (608) 266-6827.

Important Information Regarding The Worker's Compensation Division's Closure Procedure

What is a Closure Order?

Under section 102.28 (4) of the Wisconsin Statutes, the department may order an employer to cease operations in Wisconsin until the employer complies with the insurance requirements of the Worker's Compensation Act.

What happens if an uninsured employer ignores a Closure Order and continues to operate without worker's compensation insurance?

The Wisconsin Department of Justice, Office of the Attorney General, will bring action in any court of competent jurisdiction for an injunction against the uninsured employer to enforce the department's order to cease operations.

Are there penalties if I ignore a Closure Order and continue to operate without worker's compensation insurance?

Yes, they are substantial and severe. Under section 102.85 (3) of the Wisconsin Statutes, an employer who violates an order to cease operation under section 102.28 (4) may be fined not more than \$10,000 or imprisoned for not more than 2 years or both.

In addition, under section 102.85 (1) (a) and (b) of the Wisconsin Statutes, an employer who fails to comply with the insurance requirements of the Act for less than 11 days shall forfeit not less than \$100 nor more than \$1000. An employer who fails to comply for more than 10 days shall forfeit not less than \$10 nor more than \$100 for each day on which the employer fails to comply.

Finally, under section 102.85 (4) (a) of the Wisconsin Statutes, if the court imposes a fine or forfeiture under sections 102.85 (3) and/or 102.85 (1) (a) and (b), the court shall also impose an uninsured penalty assessment against the employer equal to 75% of the amount of the fine or forfeiture.

If I'm operating with employees and I don't have a worker's compensation policy, what can I do to avoid closure proceedings against my business?

Obtain a worker's compensation insurance policy immediately. Attach written documentation to this letter showing your business has obtained a worker's compensation insurance policy and the date the policy went into effect. Mail or fax the information to the Worker's Compensation Division by the date indicated on the prior page.

If I've closed or sold my business or I'm operating without any employees, what can I do to avoid closure proceedings against my business?

If you have closed or sold your business or you are operating without any employees or have filed a corporate officer option form with the Worker's Compensation Division, complete the appropriate information on the prior page of this letter. *Be sure to include the last date any employee worked for your business if applicable.* Mail or fax the information to Worker's Compensation Division by the date indicated on the prior page.

I currently have a worker's compensation policy. What should I do to help the Worker's Compensation Division's update their records to show I have a policy?

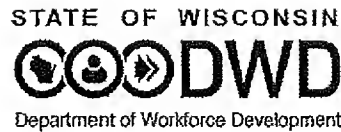
Attach a copy of the Information Page or Declaration Page of your current policy to this letter and mail or fax it to the Worker's Compensation Division by the date indicated on the prior page.

Who can I contact for more information regarding my business's status under the insurance requirements of the Worker's Compensation Act?

Call the investigator that is handling this investigation. You will find their name, telephone number and fax number on the prior page.

Scott Walker
Governor

Raymond Allen
Secretary



WORKER'S COMPENSATION
P.O. Box 7901
Madison, WI 53707-7901
FAX: (608) 266-6827

State of Wisconsin
Department of Workforce Development

COURIER DISTRIBUTION SYSTEMS LLC
% USMAN ESHA
2200 NORCROSS PKWY STE 200
NORCROSS, GA 30071-3671

May 3, 2017

BIP #: 648-88-43
WCRB #: [REDACTED]

Dear Employer:

Our records indicate we do not currently have an active worker's compensation insurance policy on file as required for your business. We have no record of a reinstatement, renewal or replacement of a worker's compensation insurance policy for you. You appear to have employees and appear to have no insurance.

To clarify our records regarding your worker's compensation insurance coverage and your status under the Wisconsin Worker's Compensation Act, please complete and return the information requested on the enclosed form. If you currently have a worker's compensation insurance policy, attach a copy of the information page, declaration page or reinstatement of your current worker's compensation insurance policy.

The following penalty information is provided only to advise you about the potential cost of lapsed worker's compensation insurance coverage. Lapsed coverage may not apply to you. The penalty for failure to carry worker's compensation insurance when required is twice the amount of premium not paid during an uninsured time period or \$750.00, whichever is greater. Under certain circumstances, an employer who has a lapse in worker's compensation insurance coverage can be subject to a penalty of \$100 for each day they are uninsured up to 7 days. In addition, an uninsured employer is personally liable for reimbursement to the Uninsured Employers Fund for benefit payments made by the Fund under section 102.81(1) of the Wisconsin Statutes, to an injured employee of the uninsured employer or to the employee's dependents.

Please complete and return the enclosed form within 15 days of the date this form was mailed. Replies to these questions are required by law. Failure to respond will be considered acknowledgment that our records are correct and will be considered evidence that you are in violation of the Wisconsin Worker's Compensation Act.

If you have any questions regarding the Wisconsin Worker's Compensation Act and your requirement to carry a worker's compensation insurance policy, please call me.

Sincerely,



Chad O'Connor, Investigator - Worker's Compensation Division
Enforcement/Investigation Unit
(608) 266-0317 Fax # (608) 266-6827 chad.oconnor@dwd.wisconsin.gov

IMPORTANT!

READ CAREFULLY

From time to time the Worker's Compensation Division may require specific information from individual employers.

If an employer receives a questionnaire or inquiry concerning its worker's compensation or employer status from the division, the employer is required by law to provide the requested information. "Every employer shall upon request of the department report to it the number of employees and the nature of their work and also the name of the insurance company with whom the employer has insured liability under this chapter and the number and date of expiration of such policy." (s. 102.28(6), Wis. Stats.)

Also every employer who fails to make the reports required by the Worker's Compensation Act shall be subject to monetary penalties. (s. 102.35(1), Wis. Stats.)

State of Wisconsin
WORKER'S COMPENSATION INSURANCE REQUIREMENTS
Department of Workforce Development

EMPLOYER'S REPORT

May 3, 2017

BIP #: 648-88-43
WCRB #: [REDACTED]

COURIER DISTRIBUTION SYSTEMS LLC
% USMAN ESHAI
2200 NORCROSS PKWY STE 200
NORCROSS, GA 30071-3671

**RE: WISCONSIN
EMPLOYEES
ONLY**

Wisconsin's Worker's Compensation Act protects employees from undue hardship and employers from liability which may result from a job-related injury. That law requires most employers of Wisconsin workers to carry private worker's compensation insurance and to respond to our requests for information. The same law requires us to make sure that employers comply.

Please complete and return pages 1 & 2 of the following form to us within 15 days of receipt to comply with the laws regulating worker's compensation. The rest of this form will answer your questions about the purpose of the Worker's Compensation Act, conditions that make an employer liable, penalties for noncompliance, and special exemptions. Call us at (608) 266-1340 if you have any other questions. ***Send the completed form within 15 days to: Worker's Compensation Division, Bureau of Insurance Programs, P.O. Box 7901, Madison, WI 53707-7901***

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)]

1. Name by which your business is known			
2. Legal name, if different from 1			
3. Business street address			
City		State	Zip Code
4. Telephone Number		5. Federal Employer Identification Number	
6. How many employees do you now have working in Wisconsin? _____ <ul style="list-style-type: none">• Count corporate officers, family members, minors and part-time employees• Do not count sole proprietors, partners, members of limited liability companies or domestic servants		If you do not currently have any employees working in Wisconsin, what was the last date any employee worked for you in Wisconsin? Date: _____	
7. How many employees do you usually have?			
8. Have you paid a combined total of \$500 or more in wages for work performed in Wisconsin during any calendar quarter (Jan - March; April - June; July - Sept; Oct-Dec) ?		This year? <input type="checkbox"/> Yes <input type="checkbox"/> No Last year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. What is the nature of your business?			

WKC-53(R. 12/2001)

(continued on page 2)

Worker's Compensation Division, Bureau of Insurance Programs
201 East Washington Avenue, Room 161 (P.O. Box 7901), Madison, WI 53707-7901
Telephone: (608) 266-1340 Fax: (608) 266-6827

State of Wisconsin
WORKER'S COMPENSATION INSURANCE REQUIREMENTS
Department of Workforce Development

EMPLOYER'S REPORT

BIP #: 648-88-43 WCRB #: [REDACTED]

10. What type of ownership is your business? If other, please explain:									
<input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation	<input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Farm Operation <input type="checkbox"/> Other, please explain _____								
11. Name the sole proprietor, partners, corporate officers, or members of a limited liability company. <table style="width: 100%;"><tr><td style="width: 60%;"><u>Name and Title (please print)</u></td><td style="width: 40%;"><u>Social Security Number:</u></td></tr><tr><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td></tr></table>		<u>Name and Title (please print)</u>	<u>Social Security Number:</u>	_____	_____	_____	_____	_____	_____
<u>Name and Title (please print)</u>	<u>Social Security Number:</u>								
_____	_____								
_____	_____								
_____	_____								
12. What insurance company currently provides your worker's compensation insurance coverage? Attach a copy of the Information Page or Declaration Page of your current worker's compensation policy.									
Name of Insurance Company: _____									
13. Policy Number: _____	14. Effective dates of the policy: _____								
15. Name of your insurance agent or agency: _____									
Telephone number of your insurance agent or agency: _____									
16. Has your business closed? If yes, on what date did it close? <input type="checkbox"/> Yes, date closed: _____ <input type="checkbox"/> No Is the business closed permanently? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If yes, what is the last date any employee worked? Last date employee worked: _____ Is the business seasonal? If yes, which months do you normally operate? <input type="checkbox"/> Yes _____ <input type="checkbox"/> No									
17. Has your business been sold or transferred? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If yes, what date was your business sold or transferred? Date sold or transferred: _____									
Provide the name and address of the person or organization who bought or received the transfer of your business: Name: _____ Address: _____									
Authorized Signature	Title								
Printed Name	Date Signed								
Telephone Number									

Thank you for completing this form. *Please mail pages 1 & 2 to us within 15 days of receipt.* The pages that follow will answer most of your questions, but call us if we can help. We are the Worker's Compensation Division of the Wisconsin Department of Workforce Development at (608) 266-1340.

State of Wisconsin
WORKER'S COMPENSATION INSURANCE REQUIREMENTS
Department of Workforce Development

Corporate Officer Option

A closely held corporation having no more than two corporate officers and no other employees may elect not to be subject to the Wisconsin Worker's Compensation Act by completing the Corporate Officer Option Notice below. Attach the completed notice to the Employer's Report form on pages 1 & 2 and mail or fax it to us within 15 days.

Please see page 5 for a detailed explanation of the Corporate Officer Option Notice and the eligibility requirements to file one. If you have any questions about whether you qualify to file a Corporate Officer Option Notice, please call (608) 266-3046 before you complete and return this form.

CORPORATE OFFICER OPTION NOTICE

Federal Employer Identification Number
Corporation Name (Please Print)
Corporation Address
City, State, Zip Code

As an officer of the above named corporation I elect not to be subject to provisions of the Wisconsin Worker's Compensation Act until such election is rescinded by written notice to the Wisconsin Worker's Compensation Division or the corporation obtains a worker's compensation insurance policy. I understand that buying a policy will cancel this election.

The corporation has no other employees or corporate officers than those listed below.

Before any employee is hired, the corporation will obtain a worker's compensation policy. I also understand that the failure to obtain a worker's compensation insurance policy, if required by the Wisconsin Worker's Compensation Act, will result in a mandatory penalty assessed by the State of Wisconsin. The penalty for failure to carry worker's compensation insurance, if required, is twice the amount of premium not paid during an uninsured time period or \$750, whichever is greater. Under certain circumstances, an employer who has a lapse in worker's compensation insurance coverage can be subject to a penalty of \$100 for each day they are uninsured up to 7 days. (ss. 102.82(2)(a) and 102.82(2)(ag), Wis. Stats.)

Corporate Officer Name (Please Print)	Corporate Officer Name (Please Print)
Corporate Officer Signature	Corporate Officer Signature
Title	Title
Telephone Number	Telephone Number
Date Signed	Date Signed

State of Wisconsin
WORKER'S COMPENSATION INSURANCE REQUIREMENTS
Department of Workforce Development

As an employer, when am I required to carry worker's compensation insurance?

Under the Worker's Compensation Act (Act), you must carry worker's compensation insurance if you do any one of the following:

1. Usually employ three or more full-time or part-time employees. You must have insurance immediately upon employing a third person.
2. Employ one or more full-time or part-time employees to whom you have paid combined gross wages of \$500 or more in any calendar quarter for work done at one or more locations in Wisconsin. You must have insurance by the 10th day of the first month of the next calendar quarter.
3. If you are a farmer who employs 6 or more workers on the same day for any 20 days during the calendar year. You must have insurance by the 10th day after the 20th day of employment. A calendar year is January through December. Note: Some of your relatives may not count as employees. Call us at (608) 266-3046 to see whether you need to count all your relatives among your employees.

Must out-of-state employers carry Wisconsin worker's compensation insurance?

Yes, you must carry the insurance if you have employees working in Wisconsin. The policy must be with an insurance company licensed to write worker's compensation in Wisconsin and endorsed to name Wisconsin as a covered state in section 3-A. Your insurance company must file the properly endorsed policy with the Wisconsin Compensation Rating Bureau. The Bureau's mailing address is P.O. Box 3080, Milwaukee, Wisconsin 53201-3080. The telephone number is (262) 796-4540. The Bureau's internet address is <http://www.wcrb.org>

Who is considered an employee and covered by the Worker's Compensation Act?

Nearly all private and public employees in Wisconsin are considered employees and covered under the Act, including:

- Part-time employees. Whether an employee works part-time or full-time has no bearing on the requirement to carry worker's compensation insurance.
- Family members. An employee's relationship to the owner has no bearing on the requirement to carry worker's compensation insurance (except for certain relatives of a farmer).
- Minors. An employee's age has no bearing on the requirement to carry worker's compensation insurance.
- Corporate officers.

Who is not considered an employee under the Worker's Compensation Act?

The following are the only workers who are not considered employees under the Act. Call us if you are not sure.

- Domestic servants.
- Any person whose employment is not in the trade, business, profession or occupation of the employer.
- Some farm employees (certain relatives of a farmer).
- Sole proprietors, partners and members of limited liability companies.
- Qualified and certified members of certain religious sects.
- Volunteers of non-profit organizations receiving salary or in-kind compensation totaling not more than \$10 per week.
- Employees of Native American tribal enterprises (including casinos), unless the tribe elects to waive its sovereign immunity and voluntarily become subject to the Act.

All worker's compensation policies exclude sole proprietors, partners or members of limited liability companies unless there is a specific written endorsement to include them. Sole proprietors, partners and members of limited liability companies may voluntarily purchase worker's compensation insurance to cover their own work-related injuries and illnesses.

What about independent contractors?

Under the Act, a person is required to meet a nine-part test before he or she is considered an independent contractor rather than an employee. A person is not an independent contractor for worker's compensation purposes just because the person says they are, or because the contractor over them says so, or because they both say so, or even if other regulators (including the federal government and other state agencies) say so. The nine-part statutory test set forth under s. 102.07(8), Wis. Stats., must be met before a person working under another person is considered not to be an employee.

State of Wisconsin
WORKER'S COMPENSATION INSURANCE REQUIREMENTS
Department of Workforce Development

What about corporations and corporate officers?

All worker's compensation policies covering corporations include corporate officers. However, in a closely held corporation, defined as a corporation with not more than 10 shareholders, no more than 2 officers may exclude themselves from coverage. If the corporation has other employees, and/or officers, an insurance policy is required and the exclusion for officers must be made by endorsement on the worker's compensation policy. The name(s) of the officer(s) must be given. The exclusion will remain in effect for the policy period. Officers who are excluded will still be counted in determining whether the employer is subject to the Act under s. 102.04(1)(b), Wis. Stats.

If a closely held corporation has no more than 2 corporate officers and has no other employees, a worker's compensation policy is not required if both officers elect not to be subject to the Act by completing and filing with the Department a Corporate Officer Option Notice. **A qualified corporation must complete and return a copy of the Corporate Officer Option Notice found on page 3.** Attach the completed notice to the Employer's Report form on pages 1 & 2 and mail or fax it to us within 15 days.

Note: A corporation with more than two corporate officers or any other employee or employees is not eligible to file a Corporate Officer Option Notice with the department and must obtain and/or maintain a worker's compensation insurance policy.

If I'm an employer who should, by law, have a worker's compensation insurance policy, but who is now operating without worker's compensation insurance, what does the law require me to do?

An employer whose worker's compensation insurance has lapsed or who has never had worker's compensation insurance is subject to penalties and closure action under ss. 102.82(2)(a) and 102.28(4), Wis. Stats., and must:

- Immediately obtain a worker's compensation policy.
- Return the completed Employer's Report form to us within 15 days of receipt.
- When assessed the penalty for the uninsured time period, pay the penalty the law requires.

What penalties may I receive for not carrying worker's compensation insurance?

We must and do enforce mandatory penalties if an employer does not obtain and maintain a worker's compensation insurance policy when required to have one. If you do not comply, you risk one or all of the following:

- You are subject to a penalty of double the insurance premiums you should have been paying during the uninsured period, or \$750, whichever is greater. Under certain circumstances, you may be subject to a penalty of \$100 for each day you're uninsured up to 7 days. (ss. 102.82(2)(a) and 102.82(2)(ag), Wis. Stats.)
- You face closure of your business, including a suspension of all operations. (s. 102.28(4), Wis. Stats.)
- You are personally liable for uninsured benefit claims for which your injured employees are eligible. (s. 102.28(5), Wis. Stats.)

How do I obtain worker's compensation insurance?

To obtain worker's compensation insurance, contact an insurance company or its agent and ask whether the company writes worker's compensation insurance for Wisconsin. If you have or know an insurance agent, you may contact him or her. If you are refused insurance coverage by a company, you may obtain coverage from the Wisconsin Compensation Rating Bureau through the Worker's Compensation Insurance Pool upon prepayment of premium. The Wisconsin Compensation Rating Bureau is located at 20700 Swenson Drive, Suite 100, Waukesha, Wisconsin. The mailing address is P.O. Box 3080, Milwaukee, Wisconsin 53201-3080. The telephone number is (262) 796-4540. The Bureau's internet address is <http://www.wcrb.org>.

Note: The Wisconsin Compensation Rating Bureau is *not* a State agency and is not part of the Wisconsin Worker's Compensation Division. The State of Wisconsin does *not* write or provide worker's compensation insurance coverage.

I currently have a worker's compensation policy. What can I do to help the Worker's Compensation Division update its records to show I have a policy?

Please attach a copy of the Information Page or Declaration Page of your current worker's compensation policy to the Employer's Report form found on pages 1 & 2 and mail or fax it to us within 15 days.

State of Wisconsin
WORKER'S COMPENSATION INSURANCE REQUIREMENTS
Department of Workforce Development

Once an employer is required to get a worker's compensation insurance policy, how long does the employer have to keep it?

Quite a while. Once an employer becomes subject to the Wisconsin Worker's Compensation Act (Act) under s. 102.04(1)(b), Wis. Stats., he or she remains subject to the Act unless the employer withdraws from the provisions of the Act under s. 102.05(1), Wis. Stats.

A subject employer is required to have a worker's compensation policy as long as he or she has one or more part-time or full-time employees. Even if a subject employer has only one part-time employee making less than \$500 per quarter, the employer must maintain the insurance for the remainder of that calendar year--and for the next calendar year--(a calendar year is January through December) before he or she is eligible to withdraw from being subject to the provisions of the Act.

If a subject employer lays off all his or her employees, the employer may drop their worker's compensation insurance while they have no employees, ***however, the employer remains subject to the Act.*** Therefore, because the employer has already become subject to the Act, ***if the employer hires an employee at a later date, the employer must have a worker's compensation insurance policy in place on the date any employee begins working.*** unless the employer has withdrawn from the Act.

Once a farmer is subject to the Act, the farmer is required to have a worker's compensation policy as long as he or she has one or more part-time or full-time employees. Even if a subject farmer has only one part-time employee, the farmer must maintain the insurance until he or she has gone a full calendar year without employing 6 or more employees on 20 or more days before he or she is eligible to withdraw from being subject to the provisions of the Act.

Note: Corporations can not withdraw from the provision of the Act. Closely held corporations (a corporation with not more than 10 stockholders) that have no more than two corporate officers and no other employees, may elect to exclude themselves from coverage under the Act by completing and filing with the Department a *Corporate Officer Option Notice*. A corporation with more than two corporate officers or any other employee is not eligible to file a Corporate Officer Option Notice and must obtain and/or maintain a worker's compensation insurance policy.

Call us at (608) 266-3046 if you are not sure whether or not you are subject to the Act or if you are not sure when you are required to have a worker's compensation policy.

As an employer, how do I benefit from the Wisconsin Worker's Compensation Act?

You receive benefits that can mean the difference between the success or failure of your business. If one of your employees gets hurt while working for you, you could be sued for damages, medical care, lost wages, and much more. By complying with the law and carrying appropriate worker's compensation insurance, you receive:

- Protection from most law suits brought by an employee because of a work-related illness or injury.
- Fair and prompt delivery of benefits to your employee who is injured on the job.
- Fair adjudication of disputes by a Worker's Compensation Division Administrative Law Judge.
- Fair and standard insurance premium rates approved by the Office of the Commissioner of Insurance.

Does my employee benefit from the Worker's Compensation Act?

If your employee does get hurt on the job, he or she can look to the worker's compensation system for prompt payment of benefits and fair adjudication of disputes.

I have additional questions regarding the requirement to obtain worker's compensation insurance. Who can I contact?

If you have questions regarding your obligation to obtain worker's compensation insurance, please write or call the Wisconsin Worker's Compensation Division, Bureau of Insurance Programs. Our mailing address is P.O. Box 7901, Madison, Wisconsin 53707-7901. Our telephone number is (608) 266-3046 or you can reach us by fax at (608) 266-6827. The Division's internet address is <http://www.dwd.state.wi.us/wc/>

DWD is an equal opportunity employer and service provider. If you have a disability and need information in an alternate format, or need it translated to another language, please contact (608) 266-1340 voice or 1-866-265-3142 TTY.



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Madison, WI



Contact: Customer Service

1 (770) 242-0454

customerservice@courierds.com

Madison is the capital of the U.S. state of Wisconsin and the county seat of Dane County. As of July 1, 2012, Madison had an estimated population of 240,323, making it the second largest city in Wisconsin, after Milwaukee, and the 81st largest in the United States. The Madison Metropolitan Statistical Area had a 2010 population of 568,593.

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(770) 242 0454

customerservice@courierds.com

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COURIER DISTRIBUTION SYSTEMS LLC

\$140,439.29

1/28/2019 9:31:38 AM	CULBEPXDIN	Spoke with the Er. There was cons. about Recalculation of the Amount, understands that If They want Int. Free, \$2,500.00 Monthly is a gift , ADD:. is Correct & Current.
8/1/2018 9:53:40 AM	CULBEPA	Er. Rep. called & stated that the Co. is operating at a significant loss but sees better days ahead , They agreed to \$ 2,500.00to show good faith hoping by Years end They can address it more realistically. Requested that We add STE.# 300 to Their ADD. :
7/27/2018 2:28:06 PM	CULBEPA	Spoke with 3'rd. Party & We discussed Their options, He will meet with Them & get back to Me A.S.A.P. & if it's an Install. Agree. I was pushing a \$2,500.00 Month Minimum we'll see.Ph. # (770)-242-0454 x 238
6/18/2018 11:56:11 AM	GALARAA	Updated address from WI to GA. Added owner, Usman Eshai, from UI Registration and James Blanchard from policy exclusion.
11/8/2017 8:51:32 AM	culbepa	Reviewed for Coverage, Lapse stands as of Today, I have Not rec. any Corr. on Wage Adjustment by Class Code.
8/21/2017 7:56:36 AM	culbepa	Reviewed File Coverage has Not been Added & to date has not seen any Actual Wages by Specific Class.
8/3/2017 11:00:40 AM	galaraa	I called and spoke with Alex Jones, Director of Risk Management, at #770-242-0454 x231. Alex had not received the penalty notification and was very surprised by the liability amount. We discussed the actual wages > estimated wages and went through the penalty calculation. The policies included two class codes, 7231 and 8810, but the penalty worksheet included only the 7231 code. Alex will review the wage total to make sure all wages were earned in WI and were earned by ee's and he will attempt to break down the wages into the correct class codes. We discussed the possibility of obtaining backdated coverage to eliminate the lapse period. Alex is making this a priority and will be in contact with the wage information in the near future.
8/2/2017 9:33:57 AM	MADIGDE	I have put in the figures into another worksheet that shows the increase in the penalty amount if I use the actual provided to me by Alex Jones. I have printed it out and provided it to Aaron, deputy collector to contact the employer
8/2/2017 9:23:57 AM	MADIGDE	I have received an email from Alex Jones, Director of Risk Management with the completed E20. The completed E20 has more wages and she lists 757 ee's. This would probably increase the penalty amount.

7/6/2017 3:00:13 PM	MADIGDE	The Website states that they operate in Madison & Milwaukee
7/6/2017 2:37:11 PM	MADIGDE	UEF App sent May 12, 2017 to: [REDACTED] [REDACTED] DOI 5/7/2017
7/6/2017 2:36:30 PM	MADIGDE	I sent the E30 to: 3935 W Mitchell St Ste 300, Milwaukee, WI % Usman Eshai
7/6/2017 2:31:54 PM	MADIGDE	E20 bounced because the address was: 650 Sugarload Parkway which is what the previous policy had for an address. I have changed it to the UI address and resent the E20
5/11/2017 1:30:45 PM	OCONNCH	New address 6650 Sugarloaf Pkwy ste 300, Duluth, GA 30097. Old address 2200 Norcross Pkwy ste 200, Norcross, GA 300713671.
3/24/2016 8:54:54 AM	GREENSE	I received a call from Matt, agent --
3/23/2016 11:43:42 AM	GREENSE	I sent E64 to customerservice@courierds.com
3/23/2016 11:43:29 AM	GREENSE	http://www.courierds.com/
3/16/2016 4:29:50 PM	GREENSE	Policy found in WCRB # 0505836 for AVITUS INC DBA AVITUS GROUP LCF ESHAI CORPORATION DBA COURIER DISTRIBUTION SYSTEMS

Department of Workforce Development
Worker's Compensation Division, Uninsured Employers Fund
201 E. Washington Ave., Rm. C100
P.O. Box 7948
Madison, WI 53707-7948



Telephone: (608) 266-5459
Fax: (608) 266-6827

08/31/2017

COURIER DISTRIBUTION SYSTEMS LLC
% USMAN ESHAI
6650 SUGARLOAF PKWY
DULUTH WI 30097-4359

Customer No.: 6488843
WCRB No.: [REDACTED]
Account No.: 64888430

PAST DUE NOTICE

Dear Employer:

Our records indicate you have not made satisfactory arrangements to pay your liability in the amount of \$ **140,100.74**. This liability was assessed under section 102.82 of the Wisconsin Statutes for failure to carry Worker's Compensation Insurance as required by law.

Your account is therefore PAST DUE and requires you to make payment immediately.

Failure to respond to this notice will be considered acknowledgment that you do not intend to pay this debt and judicial action will be required to secure payment. Judicial action may include (but is not limited to) a warrant placing a lien on all real and personal property and/or a levy against all bank accounts and attachment of any income tax refund for which you may be eligible from the Wisconsin Department of Revenue to secure satisfaction of the liability.

To avoid these collection proceedings, one of the following needs to take place **WITHIN 15 DAYS**.

1. The amount due on this account statement is paid in full.
2. If your firm is unable to make full payment, you will have to call my office to see if you qualify to establish a payment plan.

In the case of a non-response, the division will initiate the filing of a warrant against you with the clerk of circuit court in your county to secure satisfaction of this liability.

NO FURTHER NOTICES WILL BE SENT.

If you have any questions regarding your account or establishing an installment payment plan, please contact me at the number listed below.

Sincerely,

PATRICK R. CULBERT, DEPUTY COLLECTOR
WORKER'S COMPENSATION DIVISION
(608) 266-5459 FAX NO. (608) 266-6827